ENROLLMENT/CHANGE FORM VERMONT **EMPLOYEE MEDICAL/DENTAL**

Coverage Begins on the 31st day after the date of hire. If this form is submitted between the 31st and 60th day after date of hire, coverage is effective on the date this form is received by the Benefits Division.

❖ EMPLOYEE INFORMATION

Name: _____ **Employee ID:**_____

Date of Birth:_____ **SSN:** _____

Home Phone:_____ **Work Phone:**_____

Return all completed forms to:
STATE OF VERMONT
EMPLOYEE BENEFITS UNIT
144 STATE STREET
MONTPELIER, VT 05620-1701

❖ ACTION REQUEST

☐ **New Hire** ☐ **Open Enrollment** ☐ **Remove/Add Dependent** ☐ **Cancel Coverage**

If Add/Remove, please give reason and effective date (i.e. Birth, Death, Marriage, Divorce and Date)

_____

_____

❖ STATUS

☐ **Single** ☐ **Married*** ☐ **Domestic Partner** ☐ **Widowed** ☐ **Divorced** ☐ **Dissolution Domestic Partnership or Civil Union** **If status has changed, please provide date of event** _____

YOU ARE REQUIRED TO SUBMIT PROOF OF QUALIFYING EVENT TO ADD DEPENDENTS
(E.g. Marriage License, Birth Certificate, Adoption Verification, Domestic Partner Application)

❖ BENEFITS

☐ **I select the MEDICAL & DENTAL coverage to the Right (Complete 1, 2, & 3 & Dependent section below)**

#1. CHOOSE MEDICAL PLAN
☐ SelectCare POS
☐ TotalChoice

#2. CHOOSE COVERAGE
☐ Employee Only
☐ Two Person
☐ Family
(Employee + 2 or more)

#3. DENTAL COVERAGE
☐ Employee Only
☐ Two Person
☐ Family
(Employee +2 or more)

☐ **I select DENTAL ONLY** **(Provided at no cost to employees)**

PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW AND SIGN THE NEXT PAGE

❖ YOU & DEPENDENTS

RELATIONSHIP CODES: Spouse = SP; Child = CH; Domestic or Civil Union Partner = NQP

Fill in your own information on the first line. Your dependents include your spouse, civil union partner, qualified domestic partner, unmarried children under age 26, including children of your civil union or qualified domestic partner.

	Coverage Election		Person Has Other Insurance
	Medical	Dental	
Employee Coverage	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

	Coverage Election		Person Has Other Insurance		
	Medical	Dental			
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N		
Relationship: _____	**Date of Birth:** _____		☐ **Male**	☐ **Female**	**SSN:** _____

Coverage Election **Person Has Other Insurance**

	Medical	Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	**Date of Birth:** __________		☐ **Male** ☐ **Female**	**SSN:** __________________

Coverage Election **Person Has Other Insurance**

	Medical	Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	**Date of Birth:** __________		☐ **Male** ☐ **Female**	**SSN:** __________________

Coverage Election **Person Has Other Insurance**

	Medical	Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	**Date of Birth:** __________		☐ **Male** ☐ **Female**	**SSN:** __________________

Coverage Election **Person Has Other Insurance**

	Medical	Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	**Date of Birth:** __________		☐ **Male** ☐ **Female**	**SSN:** __________________

Coverage Election **Person Has Other Insurance**

	Medical	Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	**Date of Birth:** __________		☐ **Male** ☐ **Female**	**SSN:** __________________

Coverage Election **Person Has Other Insurance**

	Medical	Dental	Person Has Other Insurance	
Name: ________________	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: ____________	**Date of Birth:** __________		☐ **Male** ☐ **Female**	**SSN:** __________________

FOR MORE DEPENDENTS USE SECOND FORM

I hereby request the above action and authorize the Department of Human Resources to withhold from my wages appropriate deduction(s), if any, toward the cost of coverage. I understand that any medical information that is pertinent and necessary for the payment of claims for me or my eligible dependents can be used in accordance with the privacy rules established by the Health Insurance Portability and Accountability Act. I certify that the above information is complete and correct and that all claims submitted will only be for eligible plan members.

EMPLOYEE SIGNATURE: ____ **DATE:** _________________________